**CDC Town Hall Teleconference on**
**Colorectal Cancer Screening, Incidence, and Mortality**
**Transcript**

July 12, 2011
2:00pm – 3:00pm EST

Coordinator: Welcome and thank you for standing by. At this time all lines will be on listen-only mode. The call is also being recorded. If you have any objections you may disconnect.

I'd like to introduce Dr. Judy Monroe. You may begin.

Judy Monroe: Thank you Operator. Well good afternoon everyone. As the Operator said, I'm Dr. Judy Monroe, Director of the Office for State, Local and Territorial Support, or OSTLTS as we call it. And I'm very pleased to welcome you to CDC's July *Vital Signs* Town Hall Teleconference on Colorectal Cancer Screening, Incidents and Mortality.

Last July, CDC launched *Vital Signs* with the intent to share with our partners and the general public the current status of 12 leading health indicators in the United States. So it's - so *Vital Signs* has just celebrated the first anniversary of the first birthday for Vital Signs.

And more than just data, is a call to action and that's really what these calls are about so that we can get into the nitty gritty of how to really put into action what we know will work. *Vital Signs* is released each month. And this report shows how everyone, individuals and groups, public health officials and the public can improve these health outcomes or these health concerns and have a meaningful impact on health in our country.

It's accomplished by sharing information about what works and success stories, discussing strategies, lessons learned. And helping build networks to keep the conversation going beyond the report that came out last Tuesday.

The information released last week in *Vital Signs* is good news. It shows that progress is possible and has been made in this area. More people are being screened for colorectal cancer and fewer adults are being diagnosed with and dying from this still too common of a disease.

My background as a family physician I will tell you clinically was always a sad day to have an individual come into the office that hadn't seen a doctor for potentially a number of years. And I remember so many patients where they would be fatigued and tired and that would lead to the diagnosis of anemia, but then would lead to the diagnosis of their colon cancer.

And that was a very different story than those patients who came regularly and we were able to get the screening. And we'd find the polyps on their colonoscopy and be able to stop and nip this disease in the bud.

So as this report shows, there is much more progress that's needed. And we can save many more lives because we know this works. Today with the anniversary of *Vital Signs* I encourage all of you to consider and discuss how we can use this report to involve our communities and the media and continue this positive trend and achieving our public health mission.

So without further delay I will turn the teleconference over to Mamie Jennings Mabery from the Knowledge Management Branch here on OSTLTS who will introduce our speakers and facilitate the discussion portion of today's meeting.

Mamie Jennings Mabery: Thank you Dr. Monroe and good afternoon to everyone and thank you for joining us. Before we get started today I want to take a moment to remind everyone about the OSTLTS *Vital Signs* Town Hall Web site.

To get there you can go to the CDC site, www.cdc.gov/ostlts, and that's O-S-T-L-T-S. Once there you click twice on the Town Hall tab in the flash module at the top of the page. And then in the resources section there is a link to biographies for each of our presenters, today's PowerPoint presentation, so you can follow along as our speakers present, and a way to provide feedback.

This is also where you'll be able to find the recording and transcript of today's meeting later this week when we post it. If you have any problems viewing the PowerPoint presentation, just right click on the link and select Save As or Save Target As and this will allow you to download the presentation to your computer, which should eliminate any browser issues you may have with opening a large file.

So now it is my pleasure to introduce our speakers for today. I will introduce all of them at once and each speaker will hand off to the next one.

Joining us today to provide a summary of this month's *Vital Signs* report is Dr. Marcus Plescia, Director of the Division of Cancer Prevention and Control in CDC's National Center for Chronic Disease Prevention and Health Promotion. Our next speaker is Kathryn Chapman, Director of the Cancer Prevention Branch of the Alabama Department of Health.

Dr. Chapman will highlight her work as program manager for the Alabama FITWAY Colorectal Cancer Prevention Program, which aims to increase screening rates from men and women age 50 to 64 years. And as our last

presentation we'll hear from Susan Kuhn and Sharon Alroy-Preis. They join us from New Hampshire.

They will share information on their work engaging providers in the state. Ms. Kuhn is Primary Care Consultant for the New Hampshire Colorectal Cancer program. And Dr. Alroy-Preis is the state epidemiologist.

So now I'll turn the meeting over to Dr. Plescia for his presentation.

Marcus Plescia: Great, thanks very much Ms. Mabery. And for those of you who are trying to follow the slides if you'll just scroll up to the first slide of my presentation which is the title slide, which has my name, Marcus Plescia on it. And if you don't have the slides in front of you, you can also, I think, follow by brief comments by looking at the actual *Vital Signs* publication FAQ sheet.

What I'd like to do in the next couple minutes is just very briefly go over the main findings from this issue of *Vital Signs* about colorectal cancer and then talk briefly about some of the applications or the call to action as Dr. Monroe referred to it.

So if you'll go to the second slide which says, title, Cancer Screening in the United States Needs to be Scaled Up, so that was our initial message but actually as we got closer to the release and began formulating our main media messages, the message we were going out with on this particular issue of *Vital Signs* is that the colorectal cancer screening progress has been made, but there's significant room for improvement.

So this first slide is really looking at some of the opportunities or room for improvement. Basically the reports showed that colorectal cancer screening

rates have increased from covering 54% of the population in 2002 to 65% in 2010. So that shows significant sustained improvement over time.

But it also shows that you've got about 1/3 of patients who are eligible to be screened who aren't being screened. And that computes out to about 22 million American adults. And then also in the report as we began to drill-down and look at areas of disparity and colorectal cancer screening we found that patients who were uninsured are much less likely to be up to date with colorectal cancer screening and patient - and respondents from minority communities are also much less likely to be up to date.

If you go to the next slide which is a map, a colored map of the United States. And, actually you may find it easier to look at this map on - if you have the actual *Vital Signs* issue in front of you it's on Page 3 of that issue. And this is the other part of the message that - this is the real positive that we also wanted to emphasis in this report.

And that is that we really have made significant progress here and we've made significant progress in the things that are most important. And those things are reducing the diagnosis of colorectal cancer, and particularly reducing death from colorectal cancer.

And you know, the real issue here is that we know the cancer screening saves lives and so we look at the screening rates but ultimately what we're getting at is these rates which come from the National Program of Cancer Registry System.

So no this first slide it just shows changes across the United States by state in the diagnosis of colorectal cancer. And you'll see that about 35 of the states

have made positive improvements in decreasing the incidence rate of colorectal cancer.

And then if you'll go to the next slide this is a slide of mortality rates for colorectal cancer across the United States. And here particularly the diagram and the actual *Vital Signs* publication is a little easier to read. But this is perhaps the most hopeful of the slides. It shows that in 49 of the states, colorectal cancer mortality rates have improved and those are statistically significant improvements.

So we've really seen some very significant improvements in screening and ultimately in colorectal cancer mortality. We think much of this comes from the progress we've made in colorectal cancer screening and the worth of public health and public health communities and making this test more available and more utilized.

The next slide is just a quick review of what's recommended for colorectal cancer screening. There's one option which is what people would call fecal occult blood testing which is a test that patients can do at home. And then there are two forms of endoscopy that are recommended for screening for colorectal cancer and those are flexible sigmoidoscopy and colonoscopy.

Now the next slide shows how we're doing over time with these different screening tests. Shows which are being utilized. You see in this slide that overall we see an increased use of colorectal cancer screening tests but most of that increase has been driven by significant increases in the use of colonoscopy.

And I think of significant interest is that the use of fecal occult blood testing has actually dropped over the last eight years. And I think there's some real

opportunities here to look at that and look at this particular test for some of the patients who are less likely to be adherent for whatever reason with colonoscopy.

And I think the upcoming example you're going to have from the state of Alabama will be some good examples of how one state has attempted to do this.

My last slide which says action local and state health departments can take is a chance for me to talk a little bit about the call to action that we were trying to embrace with this particular issue. And the real push that we were making for in this issue is the idea particularly with the incoming phasing of the health reform, but there's some real opportunities to begin to look at more organized systems of screening and for public health to take a real lead role in trying to set up and advocate for some of those kinds of systems.

And we make specific mention of some of the systems in the United States that have been very effective, both the Kaiser Permanente model in North California and the New York City model. And I think in the presentations to come you'll get a sense for some of these moves towards more organized approaches to colorectal cancer screening.

I think New Hampshire has been particularly strong in some of the very organized, sophisticated surveillance systems they've used. We have a couple of recommendations here. We have focused the states that we are providing funding for colorectal cancer on a number of evidence based strategies to increase the use across the population.

But we've particularly been trying to focus on having states begin to work with Medicaid programs, since Medicaid will become much larger under

health reform. We would like to see if we can begin at looking - begin some efforts to set up some of these more organized systems where there's active outreach to patients who are eligible for screening in the Medicaid population.

And then similarly with federally qualified health centers. Again, this is a fairly large system that we feel like state health departments and local health departments could be very effective in reaching out to and working around some of the kind of systems change interventions. And I think you'll see some very specific examples of that kind of work going on in states from both the Alabama and New Hampshire presentation.

I would like to see for federally qualified health centers we actually provided some recommendations in the last page of the *Vital Signs* sheet about things that federal agencies can do. Been working very hard to try to prepare the way for states to work with federally qualified health centers by doing work with HERSA that will help support that.

I'd be very interested if there's ideas during the question and answer about ways that we at CDC might help to kind of grease up the skids a little bit for you all to work more effectively with Medicaid programs.

With that, thank you for your attention and hope that was a useful overview of what the report showed and what we hope to accomplish. And now I will turn the stage over to Kathryn Chapman from the Alabama Colorectal Cancer Prevention Program. They will talk about some of the work they're doing.

Kathryn Chapman: Thank you Dr. Plescia. My name is Kathryn Chapman and I'm the program manager of the Alabama FITWAY Colorectal Cancer Prevention Program.

I'd like to start by telling you about the efforts in Alabama to increase colorectal cancer screening rates. By telling you some of our achievements we'd like to highlight dedicated partners throughout the state.

Alabama is one of 25 states and four territories that's funded by the National Colorectal Cancer Control Program with the goal to increase screening rates to 80% in adults 50 and older by 2014. We're using the fecal immunochemical test because they're one of the three recommended screening options by the U.S. Preventative Services Taskforce. And they're a good screening option for people who have difficulty getting a colonoscopy.

Done once a year the FIT is a newer kind of test that detects hidden blood only in the lower bowel. This accurate test has very few false positives and unlike older GLIAC test, FITs don't require patients to change their diet or medications.

Large areas of Alabama are rural and have significant proportions of the population that are uninsured or underinsured. FITs are very inexpensive and therefore they're perfect for these populations that have significant screening barriers.

Eventually we hope to be helping people understand the relationship between diet, exercise and cancer. So we envision FITWAY to be a multifaceted approach to cancer prevention. Next slide.

We've been following CDC's logic model for short-term outcomes and one of these is increasing public knowledge about the importance of early detection. In year one we developed quite a bit of print materials, flyers, brochures and patient reminders. And we advertised in free magazines that are found in waiting rooms, churches, restaurants and stores.

We advertised at that Alabama and Auburn games where attendance is about 65,000 and 95,000 per game. We also advertised on AL.com which is the online home for the three largest newspapers in the state. With AL.com our ad was seen 9 million times and gave us 7,000 click-thrus to our website.

The sock puppets and the turtle are examples of print ads that were created in year one. We also ran screen for life ads in Mobile, Birmingham and Huntsville. And our website has profession and lay content with videos, peer reviews, articles and links to other sites.

In year two we created a coordinated fight back campaign that's being run on screen vision which is shown in every Rave and Carmike theater before every movie this summer. Our fight back campaign is also used in the same type of advertising venues as we used in year one. Next slide.

Another step in the logic model is to educate providers about U.S. Preventive Services Taskforce guidelines for colorectal cancer. We felt we needed baseline data for this and the Mitchell Cancer Institute and the USA polling group helped us by surveying all family practice, internal medicine and OBGYN physicians in the state.

Some of the more relevant findings were that physicians were still using the DRE to screen for colorectal cancer even though they're not an effective screening test for colorectal cancer. Also, physicians knew very little about the FIT and of those who use take home stool tests only 14% of them used the FIT.

We're using this knowledge to target our messages and provide academic detailing to physicians in their offices using CDC articles, patient literature

and sections from the American Cancer Society's toolbox. Our partners for this academic detailing are the Mitchell Cancer Institute, the American Cancer Society, the Alabama Quality Assurance Foundation, Clear View Cancer Institute in Huntsville, and medical residents from the University of South Alabama School of Medicine.

We've been purchasing FIT kits and we're giving samples of them to physicians so that they can become familiar with them. And we're also arranging for nurses and social workers in the offices where we do academic detailing to receive continuing education units when they visit the offices. Next slide.

We've been presenting at physician conferences and booths such as the Alabama Academy of family physicians and we've been advertising in physician magazines. We recently began a partnership to reach the database of Medicaid physicians and the federally qualified healthcare physicians using articles and advertisements in their magazines.

Dr. Eddy Reid is developing case studies about colorectal cancer that will be on the University of Alabama at Birmingham (UAB) continuing medical education division website where there's an established group of physicians who go there for their Continuing Medical Education (CME). Next slide.

Systems changes have been a goal in year two and three. We're partnering with the Alabama Primary Healthcare Association to develop individual protocols for each of the federally qualified healthcare centers and the community healthcare centers to help them incorporate FITs into their centers. So that patient encounters include questions about colorectal cancer screening and also so that take home FIT tests are standardized in order to be fecal immunochemical tests.

Our second goal for the federally qualified healthcare centers is to achieve a model where people can receive a FIT at the Federally Qualified Health Center (FQHC) without a physician encounter and its corresponding cost share. And they would receive it at the in-house pharmacy or the local pharmacy that has a contract with the FQHCs.

This would be accomplished with a physician standing order for the test. Once we have the protocol for the pharmacy ready, FITWAY will help by advertising to the public about the available tests.

We've been working with various manufacturers of FITs to receive locked in low pricing for the health department, the FQHCs and eventually other physicians who self identify as partnering to help our reach our goal of the 80% screening rate.

We currently have four manufacturers and distributors who have pledged at least one level of discount. Building on this success we worked with the Department of Public Health Wellness Division to change the colorectal cancer screening tests that is given at the annual wellness screening for current retired state teachers.

Formerly this test was GLIAC based and it was restricted to only those who had a first degree relative who had colorectal cancer. Now this test is a cost negotiated FIT and it's available to all of those who are age 50 and older. Last year that poll of people would have been 9,800 people. Next slide.

Electronic healthcare records have a potential to increase screening rates in a practice through a built in reminder systems and by flagging patients who are due screenings. Data show that many physicians don't know how to use the

system to their full potential. So the Alabama Quality Assurance Foundation which is the QIO for the Centers for Medicaid and Medicare in Alabama, have been teaching colorectal cancer - they've been using colorectal cancer to teach physicians how to better understand how to use their electronic healthcare records.

They're teaching their physicians to search for patients that haven't been screened for colorectal cancer, sending them an invitation to come to the office, giving them a FIT and then sending a reminder to them who have not returned their test.

We supply the physicians with sample tests, reminder cards, and those invitations to screen. With this intervention the AQAF has achieved a 55% higher take home stool test rate and a 10% higher overall colorectal cancer screening rate. Next slide.

The National Colorectal Cancer program allows 1/3 of our dollars to be spent on direct screening. We screen low risk, low income, under and uninsured men and women age 50 to 64 using providers who contract through the Alabama Breast and Cervical Cancer Early Detection program using a FIT and following that up with a colonoscopy for positive FITs.

Information about our screening program can be found at this Web site on the slide. Thank you very much for the opportunity to discuss Alabama's efforts and our partnerships and the FITWAY program to prevent colorectal cancer. Now I'll turn it over to Susan and Sharon in New Hampshire.

Susan Kuhn: Thank you Kathryn. As Mamie introduced my name is Susan Kuhn and I am on staff with the New Hampshire colorectal cancer screening program. With

me is Dr. Sharon Alroy-Preis who is our New Hampshire state epidemiologist with the Department of Health and Human Services.

The New Hampshire colorectal cancer screening program or as we affectionately call it here in New Hampshire, the CRCSP or "crispy" is very similar to the Alabama FITWAY program in that it has the same goal of increasing colorectal screening to 80% by the year 2014.

We're working to reach that goal in two ways. The first is by providing free colonoscopies to approximately 375 individuals per year who are uninsured or underinsured using patient navigators to navigate them through the process. And secondly by working with primary care physician networks and other organizations to affect systems change through evidence based population outreach strategies that have been identified by the CDC.

The next slide gives you an idea of the breadth of our working relationship with a variety of partners and ancillary organization groups. New Hampshire Department of Health and Human Services came to Dartmouth and asked us to apply for the grant due to the readiness of Dartmouth to implement the free colonoscopy part of the program within the first six months of receiving the grant.

Dartmouth had worked previously with the Department of Health and Human Services and the New Hampshire Comprehensive Cancer Collaboration program for years. And looking at their strategies and it just made sense that Dartmouth would be ready to implement the grant from the get-go.

The grant was awarded to Dartmouth Hitchcock and we immediately assumed the role of bona fide agent for the grant. However we didn't want to limit the grant to just Dartmouth Hitchcock so we expanded its reach to go statewide.

You can see from this slide that we work closely with our medical advisory board, a community advisory board, the New Hampshire Department of Health and Human Services, multiple collaborators, employers, healthcare organizations, insurers, advocacy groups and other community organizations.

We have ten colonoscopy sites that have contracted with us to provide the free colonoscopies. We are working with community health centers, federally qualified community health centers. And also primary care physician networks, the New Hampshire Colonoscopy Registry and obviously the New Hampshire Comprehensive Cancer Collaboration. So that slide just give you a sense of the partners that we are working with for this grant. Next slide.

If you saw by the framework in the previous slide, the New Hampshire Department of Health and Human Services is a key partner with the CRCSP. At a medical advisory board meeting about a year ago the issue of providers still performing in office fecal occult blood tests and as Kathryn mentioned, DREs, was discussed along with strategies to change provider behavior so they would follow the current CRC screen guidelines which obviously do not include in office FOBT.

Dr. Montero, our Director of Public Health here in New Hampshire from the Department of Health and Human Services suggested that we use our New Hampshire health alert network to try to educate physicians. So at this point I'm going to turn this slide over to Dr. Preis to talk about our Health Alert Network here in New Hampshire.

Sharon Alroy-Preis: Thank you Susan. So in New Hampshire we have the Health Alert Network, the HAN, as we have in many other states. And it's a

comprehensive 24/7 system that can provide messages, usually emergency messages, to contact people around the state.

It's a network of individuals who may respond to public health emergency. But the breadth of groups in there is really pretty wide. We have physicians, nurses, community health centers, health officers, emergency medical services, hospital contacts, CEOs and infection control practitioners. We have representation from long-term care facilities. Even school nurses and daycare providers and dentists.

So really the messages go to many people and what we have been using them until March of this year was to provide urgent information and guidelines regarding infectious disease. So when we have H1N1 or we had - in our case we had anthrax and other infectious diseases those were the times when we used the HAN.

If you go to the next slide we decided around December or January to start using this or to try using this communicator system in a different way. And we created a new message called Healthy Insights. New Hampshire Healthy Insights uses the same way, the same system, to send messages. But the type of message is different and it's prevention used for the medical community of New Hampshire.

And it can be chronic - it can also be in chronic disease fields. So the first message that we sent was about colorectal cancer. The way it is built, the Healthy Insights, we are trying to give a message that is short and concise and give really the summary of points. So there is a topic, there is a main message that is really the major message if we want to give to providers and then there is an executive summary with 3 to 5 main messages.

And then in more detailed narrative usually is not longer than a page or two. The messages also include shored guidelines and other relevant materials for providers that could be handy for providers. If you go to the next slide you'll see the issue that we had in March, which was the first published Healthy Insights in New Hampshire.

It was sent by me in collaboration with Dr. Lein Barterly from the New Hampshire Colorectal Cancer Screening program at Dartmouth. And as you see the first - the title is really the main message. That colorectal cancer is one of the few malignancies that can be prevented as well as detected early.

And under that we have three top messages that we thought were important for New Hampshire providers specifically. The first one was to alert them that only 36% of colorectal cancer in New Hampshire were detected at an early stage which is Stage 1.

Noclurplescia showed before that the rate of the incidence of colorectal cancer is decreasing and it is decreasing in New Hampshire as well. But those that do develop colorectal cancer most of them are diagnosed at a later stage. So we wanted to show providers that we have a lot of room for improvement on that front.

The second message was to say to providers if you will recommend this test to your patients they are more likely to comply with the recommendations. So keep this in mind and recommend this to your patients. And the third one was about fecal occult blood testing. And three messages in that because Dr. Barterly from her experience with seeing patients knew that that was sticking point in New Hampshire that fecal occult blood testing is not being performed only to low average risk people like it should be.

It is being performed in an office which it should not be. And sometimes when it's positive people repeat it which is wrong. So she felt that was the really important message to give to providers as one of the three main messages.

Then there is a short narrative and to this message there was an additional summary table of the guidelines. What you should do for a low risk patients, how often, what are the options for screening. Really in the one page that providers can print and, you know, paste on their office and be able to refer it again and again and again.

This was really the first time that we sent any kind of message that was not infection disease related to providers. And it was really interesting that the feedback that we got - we did get one feedback from an infectious disease specialist who said I don't - I'm not interested in getting chronic disease information.

But there was a lot of good feedback from a lot of other people who said this is wonderful, it's great that you're doing this, and wanted to join the list and get more Healthy Insight messages. So with that I will turn the stage back to Susan.

Susan Kuhn: Thank you Sharon. And we believe that New Hampshire was one of the first if not the first states to do a healthy inserts addendum to our Health Alert Network. So we were very pleased for that.

And we had found in delivering grand rounds and other lunch and learn type seminars to providers' offices that there really is a lack of knowledge out there about the correct screening modalities. And we have had doctors say to us well if the, you know, the FOBT is positive then we recommend another one.

So we know that there is much work to be done. And we're hoping that the Healthy Insights model will help us achieve that result that we're looking for. So the next slide should be the provider assessment and feedback slide.

Another key strategy for us here in New Hampshire at the CRCSP is to work with primary care providers to implement proven data driven strategies such as those identified by the U.S. Preventive Services Taskforce. Currently we're working with about 50% of the PCPs in the state to implement some of these strategies.

The most important of these is provider assessment and feedback which can include provider performance and practices, office procedures, whether they're using small media as a way to educate patients and certainly addressing barriers too with patients to mention just a few. We work with large systems to have the screening rates pulled for their population of the 50 plus individuals in their practices.

This is done we hope at the start of our work with them and we ask them to pull these statistics, these screening rates, at least two times a year. We know that without provider assessment and without provider feedback we would really have no clear indication of whether we are being successful and whether these strategies are making a difference.

So we stress that in the very beginning of our meetings with them. Since our staff is very small, the other key thing that we're doing is to reach out to our practices and ask them to identify a practice champion. The practice champion can be a clinical person, it can be an administrative person, it just needs to be someone in the practice or in the network who will help us champion this cause. And really, really drive it throughout the organization.

We have done several trainings with our champions and trained them on the CDC grant, on the data driven strategies. And then what we do is we come in and we work with them and we provide consultation to them. Some of the trainings that we've done with our champions we have trained - done a training on the CDC grant and the strategies as I've mentioned.

We've also done a training on - that we called gaining agreement which was really kind of a sales training that we wanted to provide to them because we know that they have to go into their organization and try to sell what we are trying to accomplish and sell the goal of the 80% by 2014 screening rate increase to their upper management. So we wanted to help them and give them some tools that would enable them to grain agreement from their management team.

So we've done that and we're also planning to offer training on the make it your own program for developing resources and collateral. The next slide, again, some of the other strategies that we have been employing include implementing provider and client reminder systems, consultation on practice flow which basically includes, you know, how in the practice is talking to the patient and when and how is the staff being prompted at each touch point to talk to that patient.

Whether the patient is checking in, whether the patient is being groomed by the medical assistant. Whoever is talking to that patient are they mentioning if appropriate that they are - they need to start thinking about their colorectal cancer screening.

So the other piece that we try to help them with is their EMRs to look at, you know, are the appropriate prompts being built into this system to red flag

when a patient is due or when a patient has history in the family of colorectal cancer. The results to date we have two systems that we wanted to highlight.

One is a large health system primary care practice with 12 practices and about 82 primary care providers who have increased their screening rates from 60% to 75%. And we've been working with another mid-sized health system with 11 practices and 43 PCPs. They have increased their screening rates by 11%.

So we're definitely seeing results. We're continuing our population based outreach efforts along with our free colonoscopy program to increase New Hampshire screening rates and to save lives. So I think that completes our presentation from New Hampshire. Thank you very much.